

Indiana Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 014916	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/16/2023
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NAME OF PROVIDER OR SUPPLIER HARMONY AT ELKHART	STREET ADDRESS, CITY, STATE, ZIP CODE 1129 PARKWAY AVENUE ELKHART, IN 46516
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R 000	<p>INITIAL COMMENTS</p> <p>This visit was for the Investigation of Complaint IN00416684.</p> <p>Complaint IN00416684 - No deficiencies related to the allegations are cited.</p> <p>Survey date: November 15 & 16, 2023.</p> <p>Facility number: 014916</p> <p>Residential Census: 40</p> <p>Harmony at Elkhart was found to be in compliance with 410 IAC 16.2-5 in regard to the Investigation of Complaint IN00416684.</p> <p>Quality review completed 11/20/2023.</p>	R 000		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____